Maricopa County
Group Short-Term Disability
Summary Plan Document

Effective January 1, 2005

TABLE OF CONTENTS

PLAN DESCRIPTION

What is short-term disability (STD)?

Short-term disability (STD) is a plan that provides income as a percentage of your base wage, depending on the level of coverage elected, while you are disabled. Refer to the "Terms and Definitions" section for the definitions of "Disability" and "Disabled." This plan does not provide coverage if you are unable to work due to the disability of an immediate family member.

Who is eligible to purchase short-term disability coverage?

All regular status active employees who meet benefit eligibility criteria as defined by Maricopa County (except some contract employees as specified below) and are normally scheduled to work at least 20 hours per week are eligible to purchase STD coverage. Employees working under specific contracts may or may not be eligible for certain benefits based on the terms of their contract. Please refer to the *Know Your Benefits* booklet for details on benefit eligibility criteria. The *Know Your Benefits* booklet is available at the Benefits Office located at 301 W. Jefferson St., Suite 201, Phoenix, AZ 85003. Hours are 8 a.m. to 5 p.m. Monday through Friday.

You can also obtain this booklet by calling the Benefits Office at 602-506-1010, via the EBC/intranet at ebc.maricopa.gov/hr/benefits, or through the Internet at www.maricopa.gov/benefits.

When can you enroll?

If you are eligible to purchase STD coverage, you can enroll within 30 calendar days of your hire date or within 30 calendar days of attaining benefit eligibility by completing and submitting your election on a Maricopa County Group Insurance Enrollment/Change form. Other family status changes unrelated to attaining benefit eligibility do not qualify you for enrollment into the STD plan.

If you do not elect STD coverage within the time frames listed above, you will not be able to elect coverage until the next open enrollment period.

Once an election is made, no changes will be allowed for any reason during the plan year (Jan. 1-Dec. 31).

When does coverage begin?

Coverage for new hires and employees attaining benefit eligibility through a qualified status change begins on the first calendar day of the month following either the date of hire or the event date of attaining benefit eligibility status. As specified in the "When can you enroll?" section, a completed Enrollment/Change form must be submitted within specified time frames.

Coverage for eligible employees enrolling during open enrollment becomes effective Jan. 1 following the open enrollment period.

Exception to when coverage begins

If you are not actively at work on the effective date your initial STD coverage would otherwise begin, your coverage will become effective when you return to active duty.

If your initial effective date falls on a weekend, holiday or any day that is not a scheduled workday, you will be covered if:

- You were actively at work on your last scheduled workday, and
- You were able to perform all your job duties had the effective date been a regularly scheduled workday.

Is there a pre-existing condition limitation?

If you have a disability for which you received treatment (including diagnostic services and/or prescription drugs) within 90 calendar days before your coverage became effective or for which a prudent person would have received treatment, no benefits will be payable for that condition until you have been treatment-free for three months or covered by the STD plan for 12 months.

Please note that an increase in your benefit level is subject to the pre-existing condition provision. The increase will not be paid unless you meet the pre-existing condition requirements described above.

Are there any conditions excluded from coverage?

Certain conditions are excluded from coverage. Refer to the “General Exclusions” section for details.

What benefit coverage amount can you elect?

You elect the benefit coverage amount when you enroll for STD coverage. You may elect one of the following benefit levels:

40% of base weekly earnings to a maximum benefit of $1,000 weekly.

50% of base weekly earnings to a maximum benefit of $1,000 weekly.

60% of base weekly earnings to a maximum benefit of $1,000 weekly.

70% of base weekly earnings to a maximum benefit of $1,000 weekly.

You may only increase or decrease your coverage during open enrollment. No changes will be allowed for any reason during the plan year (Jan. 1 through Dec. 31). All changes resulting in an increase in benefits are subject to the pre-existing condition language in the “Is there a pre-existing condition limitation?” section.

Example: If you previously elected a 50 percent benefit and during an open enrollment period changed your election to a 70 percent benefit, the difference between the 50 percent and the 70 percent benefit is subject to pre-existing condition criteria.

What are base weekly earnings?

Base weekly earnings is the amount of regular weekly salary or wages paid to you by your employer as of the date of your disability. This amount does not include commissions, bonuses, overtime, incentive pay, shift differential pay, any other extra compensation or any cash in lieu of benefits.

How much are the benefit contributions?

The benefit contributions for this coverage are paid entirely by you through 24 payroll deductions. The payroll deductions are taken from the first two paychecks of each month. The total cost of your coverage under this Plan depends on the benefit coverage amount you choose and your base salary. Please refer to the “Contribution Costs” section to calculate your contribution rate. Contributions are post-taxed, meaning that you pay taxes on the contribution amount, and if you qualify for the benefit, your benefit coverage amount is not taxable when received.

What is the maximum benefit duration period?

The benefit duration period is a maximum of 26 weeks beginning with the date of onset of your disability. Refer to the “Is there an elimination period before payments begin?” section for information on how the 26-week duration period is calculated.

Is there an elimination period before payments begin?

There is an elimination period of either 21 consecutive calendar days from the onset date of your disability or when all family medical leave (FML)/sick leave is exhausted, **whichever is later**. During the

elimination period, if you do not have enough FML/sick leave to cover the entire 21 days, you must use available (paid time off) PTO/vacation time through the 21-day elimination period.

After the elimination period is exhausted, you *may* request to use some, all or none of your PTO/vacation leave before you start receiving STD payments. You may not use PTO/vacation to supplement your STD payment. You also cannot be paid PTO/vacation, FML/sick leave time or regular pay for the same period you are receiving STD. Any overpayment that results in receiving both must be repaid. If you request to use PTO/vacation time, this time will reduce the 26-week duration period.

If you do not notify VPA, Inc., during your initial interview or via the online application process of your intention to save your PTO/vacation time bank, it will be treated as an offset to your STD benefit and will have the effect of reducing the number of weeks of your STD benefit.

Additionally, any partial disability payment periods or intermittent periods of work where you do not return to work at your regularly assigned position for 30 or more consecutive calendar days at 100 percent of your job's regular hours and duties will also reduce the 26-week duration period.

If you return to work for less than 30 consecutive or intermittent working days, those days count toward the 26-week duration period. Likewise, if you come back to work on a part-time basis and receive the return to work incentive benefit, those days count toward the 26-week duration period.

The elimination period is part of the 26-week maximum benefit duration period. There is a maximum of 23 weekly payments under this plan: 26-week maximum benefit duration period less three weeks (or longer if more FML/sick leave is accrued) elimination period = 23 maximum weekly payments.

What happens to your other benefits while on an unpaid leave of absence?

When you go on an approved unpaid leave of absence from your position, your portion of premiums for your benefits, such as medical and dental coverage, and the full premium amount for supplemental life insurance and STD coverage, will automatically be deducted from your STD benefit payment in order to continue coverage. Your basic life coverage will continue in force while you are on an approved unpaid leave of absence, except for active duty military leave. If you do not want to continue your benefits coverage, you must revoke it by completing an Enrollment/Change form within 30 calendar days of the beginning date of your unpaid leave of absence. However, your STD coverage may not be revoked. Contact the Benefits Office for an Enrollment/Change form. If you revoke your benefits, you must notify the Benefits Office within 30 days of your return to work to resume your benefits.

You are not eligible to receive a medical waiver payment during an unpaid leave of absence.

What happens if you terminate employment while receiving disability benefits?

STD benefit payments will continue through the time you are determined to meet the STD criteria without interruption up to the maximum 26-week benefit duration period, if you terminate employment while receiving disability benefits. Your benefit contribution for STD coverage will continue to be deducted from your STD benefit check through the time you receive your STD benefits.

What to expect if you need to submit a claim

Your STD benefits are intended to help support you and your family while you are unable to work. The claims management process used by the claims administrator is based on the types of injuries or illnesses you might encounter and on the expected length of your time away from work due to the injury or illness. Disability benefit specialists will work hard to understand your specific needs and help you in getting your disability claim approved as you move through the stages of disability and on to recovery.

The claims administrator is committed to providing you with specialized expertise and responsive service, whether for a planned absence or with assistance after a disabling accident or illness.

If you are disabled due to a mental health diagnosis, the claims administrator will work with the United Behavioral Health (UBH) Employee Outreach program to ensure you have a disability assessment, are

receiving care by a mental health professional and that you are assigned a UBH Employee Outreach Care Coordinator who will regularly work with you, the claims administrator and your mental health provider on your treatment plan and your return-to-work goals.

How do you submit a claim?

Claims can be filed in two ways: via the Internet at www.vpainc.com (24 hours a day, seven days a week) or by phone toll-free at 1-800-599-7797. Representatives are available to take your call 5 a.m.-5 p.m. Pacific Standard Time Monday through Friday.

When must you submit a claim?

If you want to receive benefits with as little break in pay as possible, you should submit your claim to VPA no later than 21 calendar days after your disability starts. However, your claim must be submitted no more than one year after the beginning date of your disability. Claims submitted beyond that date will be denied due to late filing.

Who will review your claim?

Once the claims administrator receives your claim request (including all three parts: employee, employer and attending physician's statement), you will be provided with direct access to a disability benefit specialist who will personally handle your claim. This special contact, an individual trained in disability management, will evaluate the full nature of your disability and the potential length of your time away from work, will arrange payment of the financial benefits that may be due you and will begin working with you toward your recovery and return-to-work goals as appropriate.

Is anyone else involved in the review process?

When appropriate, your disability benefit specialist will call your employer and your attending physician to better understand your condition and your potential for recovery. The claims administrator's physicians, nurses, case managers and vocational rehabilitation consultants support the disability benefit specialists and may also be in touch with your doctor. These professionals may provide review of the medical, occupational and rehabilitative information for your claim.

Additionally, if your claim is related to a mental health diagnosis, your disability benefit specialist will refer you to the UBH Employee Outreach program for a disability assessment. You will be assigned a UBH Employee Outreach Care Coordinator who will also work with you, your mental health professional and the claims administrator regarding your treatment plan and your return-to-work goals.

Participation in any case management program that VPA, in its role as the third party administrator of the STD benefit, determines to be beneficial to your return to work is required for your continued eligibility.

When will a decision be made about your claim?

Once all three portions of your claim are completed and submitted to the claims administrator, your claim will be assigned to a disability benefit specialist. With some conditions, such as standard maternity leave or recovery following a routine surgery, your benefits may begin almost immediately after the elimination period concludes.

If your medical condition is more complicated, the claims administrator may require additional medical information to better understand your claim. In any event, once the disability benefit specialist has received all necessary information, a decision will be made within four business days.

For claims with a mental health diagnosis, you will be referred for a disability assessment with the UBH Employee Outreach program. Depending on how quickly the administrator receives the additional information, your benefit determination could take longer. The claims administrator's goal is to always provide a decision as quickly as possible. Your prompt response to requests for information about your claim will help the claims administrator to serve you better and help ensure that you receive payments in a timely manner.

DISABILITY

When do disability benefits become payable?

The claims administrator (please refer to the “Plan Contact Information” section) approves payment of a weekly benefit for covered conditions after the end of the benefit elimination period and only when you and your physician or mental health professional provide documentation that you:

1. Are disabled due to illness or injury, and
2. Are under appropriate treatment and care of a physician or mental health professional.

An approval notice indicating the length of time for which disability payments have been approved will be sent. If you continue to be disabled after the disability end date on your approval notice, you must submit additional documentation of your continued disability to the claims administrator for review. Please note that the approval notice is the only notice you will receive with the disability end date. It is your responsibility to continue to communicate to your disability benefit specialist in the event your disability continues past this date. Failure to provide such information in a timely manner will result in your benefits being delayed or cancelled.

Refer to the “Terms and Definitions” section for the definition of “Disabled.”

Please note that certain conditions are excluded from coverage. Refer to the “General Exclusions” section for details.

When are claims paid?

When the claims administrator receives satisfactory proof of your claim, and your claim for disability benefits is approved, benefits payable under the plan will be paid weekly during any period that you remain disabled under the terms of the plan.

Your short-term disability check will be mailed to the address you provided when you filed your claim.

It is important that your department have your current address and telephone number while you are on a leave of absence in the event that information must be communicated to you. Please contact your Human Resources Liaison or the Employee Records Division to update your information in the payroll system.

What constitutes proof of claim?

In order for a claim to be processed, the claim administrator must receive your application for benefits, as well as sufficient objective medical evidence in support of your claim. Such evidence may consist of records from your doctor or mental health professional, narrative reports, x-rays and any other medical records, as well as evidence that you continue to be under the regular care and treatment of a physician or mental health professional. In the absence of such proof, the claims administrator may elect to suspend benefits until such proof is received.

Your disability must be supported by current objective medical evidence. You must be under the continuous care of a qualified physician or mental health professional, with a course of treatment that is appropriate for your condition.

If your doctor cannot substantiate your disability by objective findings, you may be required to see a doctor selected by the claims administrator for an independent evaluation. Failure to cooperate with such requests will result in a denial or termination of benefits.

You must give the claims administrator proof of continued disability and regular treatment by a physician or a mental health professional within 45 days of the date the claims administrator requests such proof.

Are short-term disability payments taxable?

Your STD payments are not taxable because you pay the contribution with post-tax dollars.

What conditions must be met for benefit payments to continue?

You will be paid a weekly benefit for a covered condition so long as you remain disabled and are under the appropriate treatment and care of a physician or mental health professional. You will not be paid longer than described in the “What is the maximum benefit duration period?” section.

If you continue to be disabled past the time period listed on your approval letter, you must submit additional documentation of your continued disability to the claims administrator for review. Failure to provide such information in a timely manner will result in your benefits being delayed or cancelled. Such proof will be provided at your own expense.

The claims administrator may require that you be examined as often as is reasonable, at the plan’s expense, by an independent physician/specialist, mental health professional or vocational expert of the administrator’s choice. You may also be required to be interviewed by an authorized claims administrator representative. If you fail to comply with such a request, the result will be an interruption in or termination of benefits. Benefits may also be terminated if the results of the independent examination determine that you are not disabled under the definition of “Disability.” See the “Terms and Definitions” section.

Additionally, if you are eligible to apply for long-term disability benefits, you will be required to apply for and accept payment of long-term disability benefits through the Arizona State Retirement System (ASRS).

Participation in any case management program that VPA, Inc., in its role as the third party administrator of the STD benefit, determines to be beneficial to your return to work is required for your continued eligibility.

How is your benefit payment calculated?

To calculate the amount of your weekly benefit, multiply your base weekly earnings by the percentage of the benefit coverage amount you elected and deduct any “Other Income Benefits” you are receiving that offset your benefit from this plan. Refer to the “What are Other Income Benefits?” section for more information.

Benefits payable for less than one weekly period will be paid to you at the rate of one-seventh of the STD benefit amount for each day of total disability.

How will you know when you are ready to return to work?

Because most disabilities are not permanent, the claims administrator offers return to work support in addition to providing you with financial benefits. Return to work potential is part of your claim evaluation from the start. When needed, the administrator partners with you, your physician and your employer on transitional work schedules and workplace modifications that will enable you to return to the workforce.

What is the return to work incentive?

Your employer, Maricopa County, understands that a disability can cause you and your family financial hardship. Maricopa County wants to help you reduce that hardship by providing you with an incentive to return to work as soon as you are able. VPA offers a comprehensive return to work program to assist you in returning to work. You may not be able to return full time or perform all the essential functions of your position initially. However, the County and VPA will work with you and your doctor if your disability benefits specialist determines you are a good candidate for participation in transitional duty prior to returning to full duty (working your usual schedule and performing all your pre-disability job functions). VPA will continue to support your recovery by continuing to pay a portion of your STD benefit within certain limits in addition to your part-time earnings.

Participation in the “return to work incentive program” is mandatory for you to continue receiving STD benefits if you are considered an appropriate candidate for the program and there is an assignment available that meets your medical restrictions and for which you are qualified.

If your leave is covered under the Family Medical Leave Act (FMLA), however, you can choose to decline participation (you still will not receive STD benefits). You may choose to use any PTO/vacation you still have available through the end of your FMLA leave.

If, however, you are not covered under the FMLA and have been released to return to work by your health care provider with restrictions which Maricopa County can accommodate, the County will require you to return to work and participate in this program. Failure to return to work under these circumstances may result in disciplinary action up to and including dismissal.

How will you be paid while you are in this program?

When you add your gross part-time earnings to your weekly STD benefit, the total is limited to the lesser of your regular STD benefit or 80 percent of your pre-disability gross earnings. If your weekly STD benefit and your gross earnings exceed 80 percent of your pre-disability earnings, then your STD benefit will be reduced so that the total amount of gross wages and the STD benefit equals 80 percent of your pre-disability wage.

EXAMPLE: An employee who normally works a 40-hour week is on STD. The doctor releases the employee to return to work part –time, no more than 20 hours per week.

Pre-disability gross wages for 40 hours =	$480 ($12/hour)
STD Benefit Level	70%
Standard STD Benefit	$336 ($480 x 70%)
Part-time Gross Wages	$240 ($12 x 20 hours)
80% of Pre-disability Gross Wages	$384 ($480 x 80%)

Part-time Gross Wages ($240) + STD Benefit ($336) = $576

$576 exceeds 80% of pre-disability wages ($384)

Because the STD benefit plus gross part-time earnings ($576) cannot exceed 80 percent of the pre-disability wage ($384), the STD benefit is reduced from $336 to $144 ($240 [part-time earnings] - $384 [80 percent of pre-disability wages]).

Without the return to work incentive, the part time wages would offset the standard STD benefit ($336 - $240 = $96 STD benefit). By using the return to work incentive, the employee has an increased STD benefit of $48 per week ($144 - $96 = $48).

The return to work incentive will begin with the first day you return to part-time work. It will continue for a period of up to 21 weeks elapsed time or until you stop working part-time and are totally disabled (your full disability benefit will continue in that case) or when you are no longer disabled, whichever occurs first. Once you begin to receive the return to work incentive benefit, the 21-week period will continue to count down until 21 weeks have elapsed. Intermittent periods of total disability or partial disability under the return to work incentive will count toward the total 21-week return-to-work incentive benefit period, even if you do not receive the full 21 week incentive benefit during that 21 week elapsed time. After receiving up to 80 percent of your pre-disability income for up to 21 weeks, your benefits will either:

1. Revert to zero because you have returned to full employment, or
2. Revert to the standard total disability benefit based on your pre-disability election

What happens if you are out of work for a long time?

If your claim is or becomes long term and you are covered under the ASRS, the claims administrator will advise you to apply for long-term disability. The claims administrator will make this contact after you have been off work for 90 days and it appears that your disability will continue for more than an additional 90 days.

What are Other Income Benefits?

Other Income Benefits offset the amount of your STD payment. You are responsible to report the receipt of other income immediately upon receipt to the claims payer or your disability manager. If it is discovered

after the fact that an offset did not occur, you will be required to pay back the money owed. Other Income Benefits include, but are not limited to, the following:

1. Applicable amounts provided under any workers' compensation law (including pay continuation program)
    a. Transitional Duty
    b. Supplemental Pay Program (workers' compensation coordination)
2. Any payments you are entitled to receive under the No Fault Insurance award or through Third Party Subrogation. Note: If such payments are received during or following the end of your disability payments, you are liable to pay the plan an amount equal to the settlement amount or the amount of disability benefits received, whichever is less.
3. Any benefits you or your dependents are eligible to receive because of your disability or age under the United States Social Security Act or similar plan or act. If benefits from these programs are denied for any reason (except your non-insured status), you will be required to appeal the denial to the full extent permitted. You will continue to be considered eligible to receive STD benefits until all appeal processes are exhausted.
   Note: If Social Security Disability payments are received retroactively to cover a period of time during which you were covered and paid benefits from the STD plan, you are liable and responsible to pay the plan an amount equal to the retroactive amount received from the corresponding period or the amount of disability benefits received, whichever is less.
4. Any benefits you are eligible to receive under any plan or provision providing periodic payments for disability or providing benefits for loss of time or income to which your employer, union, trade or professional organization directly or indirectly sponsored or contributed.
5. Any benefits available from any Salary Continuation Plan, including, but not limited to, workers' compensation income protection, sick leave, PTO/vacation, family/medical leave (FML) or donated leave.

What happens if you receive a lump sum payment from Other Income Benefits?

If a lump sum payment is received retroactively to cover a period of time during which you were covered and paid benefits from the STD plan, you are liable and responsible to pay the plan an amount equal to the retroactive amount received from the corresponding period or the amount of disability benefits received, whichever is less.

If no time period is given for the lump sum, you are liable and responsible to pay the plan an amount equal to the full amount of the lump sum received or the full amount of disability benefits received, whichever is less.

When do short-term disability benefits stop?

STD benefits stop on the earliest of:

1. The end of the pay period in which you stopped paying your benefit premium;
2. The date you are determined to be no longer disabled;
3. The end of the plan's maximum benefit duration period including any partial benefit payment periods;
4. The date of your death.

What happens if I return to work and become disabled again?

If you are disabled, return to work and become disabled again due to the same or related cause, the second disability will be considered a continuation of the first period of disability, as long as you had returned to work for less than 30 consecutive calendar days.

If your second disability is unrelated to the first, or if you have returned to work for 30 or more consecutive calendar days, the second period of disability will be considered a separate claim, any accrued FML must be used and a new elimination period must be satisfied before benefits will become payable.

GENERAL EXCLUSIONS

What disabilities are not covered?

This plan will not provide payments for any disability benefits if:

1. You are not under the direct and regular care* of a licensed physician or mental health professional and are not receiving medical treatment* as defined in the “Terms and Definitions” section;
2. You participate in a felony and become disabled as a result of such participation;
3. You are confined in any penal or correctional institution as a result of a conviction for a criminal or other public offense;
4. Your disability is the result of a war or act of war, unless you are a United States expatriate or on temporary assignment in a war area on employer business or you are in the military service of any country which is at war;
5. Your injuries are sustained while you are on a personal leave of absence without pay, excluding jury duty and vacations (see “Active Employment” in the “Terms and Definitions” section).
6. You have a vague or undefined condition (such as “tiredness” or “pain”) for which your doctor cannot provide a medical diagnosis;
7. You have cosmetic or elective surgery, except surgery made necessary by accidental injury incurred while covered under the plan;
8. You have an injury, sickness or pregnancy for which you receive, or a prudent person would have received, medical treatment within the three months before the date of your coverage under the STD program. This exception does not apply to disability commencing after a plan participant has been covered under the plan for a period of 12 continuous months.

TERMINATION

When does coverage terminate?

You cease to be covered on the earliest of the following dates:

1. The date your employer discontinues the plan,
2. The date you retire under any normal retirement plan or your employer's retirement plan,
3. The date you cease to be a benefit-eligible employee,
4. The date of your death,
5. The last day of the coverage period for which contribution was made,
6. The last day of the pay period in which your employment ends unless you are disabled on or before the date your coverage terminates and would otherwise be entitled to benefits for that disability. In that situation, benefits will be payable as though coverage had not terminated. Benefits under this extension will be payable only if the disability continues without interruption. STD contributions will continue to be deducted from your disability benefit for as long as you remain eligible.

How will you be notified about the decision regarding your disability application?

The claims administrator will advise you of a decision within four business days of receipt of your complete claim information for disability benefits. In the event your claim is denied, you will receive a written notice from the claims administrator, which will include:

1. The specific reason or reasons for the denial, with reference to those plan provisions on which the denial is based;
2. A description of any additional material or information necessary to complete the claim and an explanation of why that material or information is necessary; and
3. An explanation of the steps to be taken if you or your authorized representative wish to have the decision reviewed.

Note: If the claims administrator does not respond to your claim within the time limits set forth above, you should contact the claims administrator or your disability manager to request a status on your application.

What happens if you disagree with the claims administrator's decision on your claim?

The claims process is designed to ensure that your claim receives a thorough, fair and objective evaluation. In addition, numerous safeguards are in place throughout the process to ensure the integrity of the decisions that result from the administrator's evaluation. If benefits are determined as not payable either in whole or in part, you may appeal the decision by requesting a separate, impartial review from the claims administrator.

You or your authorized representative may appeal a denied claim within 60 days after you receive the claims administrator's notice of denial. You have the right to:

1. Submit a written request for review to the claims administrator at:

   VPA, Inc.
   Attn: Claims Manager
   P.O. Box 9830
   Calabasas, CA 91372-0830

2. Review pertinent documents; and
3. Submit issues, comments and additional supporting documentation, in writing, to the claims administrator.

The claims administrator will make a full and fair review of the claim and may require additional documents as it deems necessary or desirable in making such a review. A final decision on the review will be made no later than 60 days following the claims administrator's receipt of your written request for

review unless an extension is required due to special circumstances. If special circumstances require an extension of time for processing, you will be notified of the reasons for the extension, and a decision will be made no later than 120 days following receipt of your request for review.

The decision of the claims administrator is the final decision. The final decision on review will be furnished in writing to you and will include the reasons for the decision with reference to those plan provisions upon which the final decision is based.

If this does not satisfactorily resolve your claim, you should send a letter to the VPA Director of Claims, P.O. Box 9830, Calabasas, CA 91372 within 20 days of the receipt of the Level 1 appeal denial. Your written appeal is to include your statement of the general nature of the appeal; a copy of the Level 1 denial letter; a statement of the factual circumstances giving rise to the appeal, a summary of the action already taken prior to filing the appeal and a statement as to the remedy you seek to resolve the appeal.

How do you resolve a service issue with the claims administrator?

If you are having a service issue with the claims administrator that you are unable to resolve by contacting the administrator, you may file a formal complaint through disability management. Refer to the "Plan Contact Information" section of this booklet for contact information.

Disability management will ask that you put your complaint in writing. The Customer Report of Dissatisfaction form is available online through the EBC Intranet and the Internet Benefits Home Page. The disability manager will work with the administrator to resolve your service issue.

What is the role of disability management?

The disability management unit of the Employee Health Initiatives Division of Maricopa County will be available to answer general questions about the STD plan and how it functions within Maricopa County. The unit's primary role is quality control regarding customer service and payment of benefits. Disability management can be reached by calling (602) 506-1010.

CONTRIBUTION COSTS

Short-Term Disability (STD) Plan

100 percent Paid by Employee
$1,000 weekly maximum benefit

STD Options	Rate Multiplier for 24 Pay Periods	Maximum Base Monthly Salary Subject to Contribution Calculation
40% of Biweekly Base Salary	$0.0035	$10,835
50% of Biweekly Base Salary	$0.0050	$8,668
60% of Biweekly Base Salary	$0.0065	$7,224
70% of Biweekly Base Salary	$0.0080	$6,192

Short-Term Disability Contribution Calculation Example

Base Annual Salary:	**$25,000**
Base Annual Salary divided by 12 months = Monthly Salary	$25,000 ÷ 12 = **$2,083.33**

Base Monthly Salary: **$2,083.33**	40% Option	50% Option	60% Option	70% Option
Monthly Contribution = Base Monthly Salary (up to Maximum Base Monthly Salary) multiplied by Rate Multiplier	$2,083.33 X 0.0035	$2,083.33 X 0.0050	$2,083.33 X 0.0065	$2,083.33 X 0.0080
Monthly Premium	$7.29	$10.42	$13.54	$16.67
Pay Period Contribution = Monthly Contribution divided by 2	***$3.65***	***$5.21***	***$6.77***	***$8.33***

TERMS AND DEFINITIONS

Many terms used in this booklet have special meanings. A list of these terms and their meanings follows.

"Active Employment" means you must currently be working:

- For your employer in regular status and paid regular earnings,
- At least the minimum number of hours shown under the eligibility section in the *Know Your Benefits* booklet, and
- At your employer's usual place of business or a location to which your employer's business requires you to travel.

Note: Employees working under specific contracts may or may not be eligible for certain benefits based on the terms of their contract. Each appointing authority, in conjunction with the Total Compensation Department, determines if contract employees are benefit eligible.

"Base Weekly Earnings" means the amount of regular weekly salary or wages paid by your employer as of the date of your disability. This does not include commissions, bonuses, overtime, performance incentive pay, shift differential pay or any other extra compensation or cash in lieu of benefits.

"Complications of Pregnancy" refers to that part of the pregnancy during which abnormal conditions or concurrent disease significantly affect the pregnancy's usual medical management. A complication may exist 1) during the pregnancy, 2) during the delivery or 3) after the delivery. Complications of pregnancy do not include an elective cesarean section.

"Disability" and **"Disabled"** mean that because of illness or injury you cannot perform each of the essential functions of your regular occupation and you are not working in any occupation. Furthermore, you are not considered disabled or under a disability unless you are under the regular care and medical treatment of a licensed physician or mental health professional who is practicing within the scope of his/her license or certification during the entire period of disability.

"Disability Benefits" means money that is paid as a weekly benefit when your claim has been approved.

"Elimination Period" means either 21 consecutive days from the date of onset of your disability or when all FML/sick leave is exhausted (whichever is later) during which time no short-term disability benefits are payable.

"Employer" means Maricopa County and includes any department, division, subsidiary or affiliated company named in the plan.

"Gross Weekly Benefit" means the disability benefit amount before any reduction or offset for other income benefits and earnings.

"Illness" means sickness, disease or other medical conditions including pregnancy or mental health conditions. The disability resulting from the illness must begin while you are covered under the plan.

"Injury" means bodily injury resulting directly from an accident and independently of all other causes. The disability resulting from the injury must begin while you are covered under the plan.

"Maximum Benefit Duration Period" means benefits will continue up to a maximum of 26 weeks (maximum of 23 checks) beginning with your date of disability, which includes any FML/sick leave accruals and the benefit elimination period and any partial disability payment periods or intermittent periods of work where you do not return to work for more than 30 consecutive days at 100 percent of the job's regular hours.

"Medical Treatment" means that you have consulted, or received the advice of — including advice given during a routine examination — a licensed medical or dental practitioner or mental health professional. It also includes situations in which you have received medical, dental or mental health care, treatment or services, including taking drugs, medication, insulin or similar substances.

"Mental Health Professional" means a person (other than you, your spouse, child, brother, sister or your parent or the parent of your spouse) who is operating within the scope of his/her license and is a:

- Licensed psychiatrist;
- Licensed clinical psychologist, or
- Licensed masters level mental health clinician/therapist, such as a social worker or counselor.

"Net Weekly Benefit" means the disability benefit amount after any reduction or offset for other income benefits and earnings.

"Partial Disability" and **"Partially Disabled"** mean that because of illness or injury you are unable to perform all the essential functions of your regular occupation on a full-time basis, and you are performing at least one of the essential functions of your regular occupation or another occupation on a part-time or full-time basis.

"Physician" means a person (other than you, your spouse, child, brother, sister or parent, or parent of your spouse) who is:

- Operating within the scope of his/her medical license; and is either
- Licensed to practice medicine and prescribe and administer drugs or to perform surgery; or
- Has a doctoral degree in psychology (PhD or Psy.D) and whose primary practice is treating patients; or who is
- Legally qualified as a medical practitioner according to the laws and regulations of the governing jurisdiction.

"Regular Care" means you personally visit a physician or mental health professional as frequently as is medically required according to generally accepted medical standards to effectively manage and treat your disabling condition(s); and you are receiving the most appropriate treatment and care which conforms with generally accepted medical standards for your disabling condition(s) from a physician or mental health professional whose specialty or experience is the most appropriate for your disabling condition(s) according to generally accepted medical standards.

"Regular Occupation" means the occupation and job tasks as defined under the essential job functions section of the Maricopa County personnel job requisition in place at the time your disability began.

"**You**" and "**Your**" means you, the employee.

PLAN CONTACT INFORMATION

Name of the plan

Maricopa County Short-Term Disability Plan
Group Number 435000

Name and address of employer

Maricopa County
301 W. Jefferson St.
Phoenix, Arizona 85003

Who pays for the plan?

Participating employees pay the cost of this plan.

Plan sponsor/plan administrator

Maricopa County Total Compensation
Employee Health Initiatives Division
301 W. Jefferson St., Suite 201
Phoenix, AZ 85003

Agent for service of legal process

Plan administrator as stated above.

Claims administrator

VPA, Inc.
P.O. Box 9830
Calabasas, CA 91372-0830

Customer service telephone number: (800) 599-7797
Fax number: (818) 591-7664

Disability management at Maricopa County

Maricopa County
Employee Health Initiatives
301 W. Jefferson St., Suite 160
Phoenix, AZ 85003

Phone: (602) 506-1010, press 2 for Benefits, then press 3 for short-term disability
Fax: (602) 372-8574